

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-010086

STATE FILE NUMBER

Registration District No. 352 Primary Registration District No. _____ Registrar's No. 13

FILED FEB 25 1963

1. PLACE OF DEATH a. COUNTY <u>Taney</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Taney</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Forsythe</u>		Length of stay in 1b <u>1 year</u>	c. CITY OR TOWN <u>Forsythe</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lakeview Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>PEARL</u> Middle <u>BROWN</u> Last <u>BROWN</u>			4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>63</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-86</u>	9. AGE (last birthday) <u>76</u>	10. IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		
11. BIRTHPLACE (City and state or country) <u>Farlinville, Kansas</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>		

13a. FATHER'S NAME <u>Ezra D. Mumford</u>		13b. MOTHER'S MAIDEN NAME <u>Louisa Griggs</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Joe R. Aid, Sr. West Plains, Mo.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT <u>Mrs. Joe R. Aid, Sr. West Plains, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterial Hypertension</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____ Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	

21. I attended the deceased from 11-17-61 to 2-6-63 and last saw her alive on 2-5-63
Death occurred at 2-6-63 1:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Mary King, D.O.</u>	22b. ADDRESS <u>Forsythe, Mo.</u>	22c. DATE SIGNED <u>2-15-63</u>
--	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-6-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shady Grove</u>	23d. LOCATION (City, town, or county) <u>Bald Knob White Ark</u>
---	----------------------------	--	---

24. FUNERAL DIRECTOR <u>Powell Funeral Home</u>	ADDRESS <u>Bald Knob, Ark.</u>	25. DATE RECD. BY LOCAL REG. <u>2-20-63</u>	26. REGISTRAR'S SIGNATURE <u>Deleu Campbell</u>
--	-----------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1060

21060

3

4 1

5 2

6

7 1

8 2

9331X

10

11

1286-2

131-0

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

FEB 26 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Walter Cook

Licensed Embalmer No. 731

P. O. Address Osman 7th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.